Please print clearly and complete fully.
Patients 16 & older MUST sign all forms
****Use Blue or Black ink ONLY****

Date: _____
Provider: _____
Revised 8/31/17

Minnesota
Mental Health Clinics

Intake Information

PCN#_____

Client's Name _____

Parent / Guardian / Legal Representative_____
**If patient is under 18-Do you have full custody of child? (*circle one)* Yes or No
If No-please list legal guardian/parent _____
(Legal guardianship paperwork must be provided to the clinic if different from parents)

Client Information

Address_____

Apt. _____ City _____ State _____ Zip Code_____

Primary Phone #1 _____ Phone #2 _____ Phone #3_____

DOB _____ Social Sec. #_____Occupation _____ Employer _____

Client's Identified Gender and Preferred Pronouns_____

Your Spouse (or if child, Parent or Guardian Information)

Name _____ DOB_____ Address _____

City _____ State _____ Zip Code _____ County _____

Primary Phone #1 _____ Phone #2 _____ Phone #3_____

Relationship to Client _____ Employer _____

Reason for seeking counseling at this time: _____

Do you have any serious medical problems or infectious diseases?_____

Marital Status: Single Engaged Married Separated Divorced Widowed Cohabitating For how long? _____

Who Referred You? _____ Religious Affiliation (optional) _____

Race/Ethnicity/Tribe _____ Nation of Origin _____ Length of Time in US _____

Preferred Language _____ Is an interpreter needed for services? _____

Current Medication _____

Names and Dates You Saw In the Past: Psychiatrist, Psychologist, Counselor, and/or Therapist:

_____

Insurance Company _____ Policy ID _____ Group # _____

Policy Holder _____ DOB _____ Social Sec _____

Address _____ City _____ State _____ Zip Code _____

Contact Phone # _____ Employer _____ Relationship to Client _____

Emergency Contact: Name and Phone number: _____
(If unable to contact you, who can we call?

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Consent for Services

Guarantee of Account: I agree to pay Minnesota Mental Health Clinics for all charges for services not covered by any third party payer. I understand that I am responsible to comply with the rules and regulations of my insurance company regarding pre-certification and prior-authorization requirements. I agree if a pre-authorization of service is required, unauthorized visits are my responsibility for payment. We will assist you in keeping a count of your number of sessions used.

Insurance Consent: I request that payment of authorized benefits be made directly to Minnesota Mental Health Clinics, and the facility's participating physicians and therapists, for any services furnished to me. I authorize this facility to release to Medicare, and other accident or health insurer, medical or financial information as needed for claims processing, fraud investigation, or quality of care review and studies.

Transportation: I authorize Minnesota Mental Health Clinics to release to my transportation company information regarding my appointment attendance.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider working for this facility involved with my current treatment. I understand that other agency personal involved in billing, medical records and other necessary duties may see my medical records. I understand that a facility representative who is conducting a Rule 29 case consultation or a quality of care review may access my record. I further understand that a representative may contact me after discharge, and that information from my medical record has been made available to that representative. The representative will seek your opinion about the helpfulness of services and about any problems you may have had. We will follow any direction you may have had for us to contact you on the "Treatment Agreement" form.

Consent for Personnel in Training: I am aware that clients at this facility may be attended by medical, nursing, and/or other mental health care personnel in training, who may be present during client care as part of their education.

I hereby agree to the above and that a photographic copy of this authorization is as valid as the original. This authorization expires after one year but may be revoked or limited in writing by me at anytime, but such revocation will not apply to information already released. I may disagree with the use of my medical record for any purpose listed above by crossing through the paragraph and initialing in the left margin. I understand that if I refuse or revoke consent to release information, this may change my providers' ability to continue providing services.

Client Name (please print) _____

Signature _____ Date: _____

Parent or Guardian Signature _____ Date: _____

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Treatment Agreement

Privacy Policy and Client Rights and Responsibilities: The privacy of your medical information is important to us and we are committed to protecting it. A record of your care will be created for the services received while a patient at our office. This record is necessary to provide you with quality care and to comply with certain legal requirements. Your medical information may be disclosed to other treating providers at your request, your insurance company to assist in payment of your claim and to pharmacies to assist in obtaining your medications. Full notice of our privacy policy is posted on our waiting room wall. You are being given a copy of your rights and responsibilities. **My signature on this form acknowledges I have read this policy and have been informed of the privacy policy of this office.**

Complaints, Grievances, or alleged violations of rights: I have received a copy of the procedure to report a complaint, grievance or rights violation and understand its contents. You have the right to file a complaint with us about our privacy practices or our compliances with our Notice of Privacy Practices, our Privacy Policies and Procedures, or federal or state privacy rules or law. The contact information to do so is: Minnesota Department of Health and Human Service, 540 Cedar St, St Paul, MN 55101, (651) 431-2000

Mental Health Services: I give permission to Minnesota Mental Health Clinics to evaluate, administer diagnostic testing, prescribe medication, develop a treatment plan and provide treatment with my participation. I understand that the practice of medicine and psychotherapy is not an exact science and I acknowledge that no guarantees have been made to me as the result of assessment or treatment in this facility.

After Hours Emergency: If there is an after hour emergency, I can call the agency and follow the directions given on the recording or refer to the list I've been given for crisis assistance.

Telephone Confidentiality: In the event the Minnesota Mental Health Clinics staff must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Unless you give us other instructions below, we will call your home and/or office, first we will ask to speak to the client or guardian without identifying the name of the agency (to protect confidentiality). If necessary we will identify ourselves as your therapist's/provider's office, we do not say the name of the agency or nature of the call, but rather the mental health professional's name only. If we reach an answering machine or voice mail we will follow the same guidelines. If you'd like us to contact you by another procedure, please list where we may reach you by phone and how you would like us to identify ourselves. Include phone numbers and how you would like us to identify ourselves when phoning you.

I wish to be contacted in the following manner (check all that applies):

Home Telephone: _____
___ OK to leave message with detailed information
___ Leave message with callback number only

For Written Communication:
___ OK to mail to my home address
___ OK to mail to my work/office
___ OK to fax to this number: _____

For Email or Texting:
Email address: _____

Cell Phone: _____

___ OK to leave message with detailed information
___ OK to send appointment information
___ Ok to send customer surveys
___ Ok to send communications on services or offerings

Work Phone: _____

___ OK to leave message with detailed information
___ Leave message with callback number only

Client Name (please print) _____

Signature_____ Date: _____

Parent or Guardian Signature _____ Date: _____

Parent or Guardian (please print) _____

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Fee Policies and Authorization of Benefits Agreement

Fees/Insurance
If you plan to submit your own claims to your insurance company, it is our policy that payment of the entire fee is due at the time of service.

As a service to our clients, Minnesota Mental Health Clinics staff will submit your insurance claims. Please provide us with the necessary information. **CO-PAYMENTS, OUTSTANDING BALANCES, AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.**

Minnesota Mental Health Clinics can make no guarantee that your insurance company will provide payment for services rendered. **IT IS YOUR RESPONSIBILITY TO KNOW WHAT IS AND IS NOT COVERED UNDER YOUR POLICY. YOU ARE RESPONSIBLE FOR THE FULL AMOUNT OF THE CHARGE, WHETHER OR NOT YOUR INSURANCE WILL COVER ANY PORTION.** If your insurance company requires preauthorization of services you are responsible to inform us. Be aware that most insurance companies have an annual maximum benefit for outpatient mental health coverage. Time billed for court appearances, court case review, report writing, telephone consultation and other charges excluded by insurance coverage are client responsibility.

A service charge of 1.5% (18% annual rate) or the highest statutory amount allowed, whichever is higher, will be charged on accounts past due 60 days. If payment from insurance is not received within 90 days the account is due and payable in full. Accounts 90 days past due will be subject to collection procedures and/or small claims court, the client agrees to be held responsible for the cost disbursement including reasonable attorneys, collection and court fees. There is a fee of $20 for checks returned for insufficient funds.

Medical Records
There is a fee for the copies as defined is Minnesota State Statute 144.292

Cancellations
We ask that you give us 24-hour notice during regular business hours when canceling an appointment. This will allow us to schedule the time for someone else. To cancel an appointment, please call 651-454-0114 during regular office hours. Please **NOTE: IF YOU FAIL A SCHEDULED APPOINTMENT OR CANCEL WITH LESS THAN A 24 HOURS NOTICE OR CALL OUTSIDE OF REGULAR BUSINESS HOURS, YOU MAY BE CHARGED FOR THE SESSION.** Your insurance cannot be billed for missed appointments. If you fail or cancel an appointment with less than 24 hours notice of the scheduled appointment two times in a row or three times in a six-month period, it is possible that you will be referred to another clinic for future service. Final decisions are made by the provider.

I HAVE READ AND AGREE TO THE ABOVE AND HEREBY GUARANTEE PAYMENT OF ALL CHARGES FOR PSYCHOLOGICAL SERVICES WITH THE FINANCIAL ARRANGEMENTS OF MINNESOTA MENTAL HEALTH CLINICS. ANY SPECIAL ARRANGEMENTS CONTRARY OR IN ADDITION TO THE ABOVE ARE WRITTEN BELOW.

I hereby authorize the release of any medical information necessary to process this claim to the insurance company and/or the responsible party for this account. I authorize payment of medical benefits for services rendered to me and/or my dependents to Minnesota Mental Health Clinics.

Client Name (please print): _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Insurance Company: _____

Group & Policy Numbers: _____

Mailing Address: _____

_____

A copy of this authorization shall be as valid as the original

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CLIENTS' RIGHTS AND RESPONSIBILITIES

Welcome to the Minnesota Mental Health Clinics. Our staff will be continually working to provide you with appropriate, high quality services. We believe that a client who understands and participates in his/her case may achieve better results. We have the responsibility to give you the best care possible, to respect your rights and recognize your responsibilities as a client. We have prepared this information to help you identify these rights and responsibilities.

YOUR PRIVACY RIGHTS

As a client of this clinic you have a right to privacy and to review information we keep in your file. Under of the Minnesota Data Privacy Practices Act and the Health Insurance Portability and Accountability Act you have the right to:

1. Be told why the information we request is needed.
2. Be told how the information will be used.
3. Be shown all information about yourself.
4. Be told of the consequences of refusing to supply the requested information.
5. Contest the accuracy of information in your file.
6. All information about you will be kept private.

You will also receive a brochure titled, "Your Privacy" which details the use and handling of your protected health information. Please read this brochure carefully to understand how medical information about you may be disclosed and how you can get access to it.

If you have any questions about your Privacy Rights, please contact your therapist or the Clinic Director.

RIGHT TO DIGNITY You have a right to be treated with dignity and respect and to receive the same consideration and treatment as anyone regardless of your race, creed, religion, disability or sexual or affectional preference.

RIGHT TO UNDERSTAND You have a right to be informed of the staff's assessment of your problem in language you understand; treatment alternatives; possible outcomes and side effects of treatment, expected length; cost and hoped for outcome of treatment. In addition, you have the right to and responsibility to help develop your own treatment plan.

You also have a right to understand why information requested about you is needed. In general, such information is used to determine whether you are eligible for services, to help us evaluate your needs for services and develop a plan to meet those needs, and to collect information from others, which will be helpful in developing an effective treatment plan.

You have the right to understand how the information requested of you will be used. The information we collect will be used by staff members of the Minnesota Mental Health Clinics for clinical management, planning and evaluation purposes. No information will be released to any other agency or individual without your written consent within the exceptions outlined above.

Clinical information relating to your social history and present concerns is necessary in order for our staff to correctly and completely assess your needs and develop a plan for meeting them. If you do not supply such information, it cannot be determined which services are most appropriate for you and will make it difficult for us to carry out an effective treatment plan for you and/or your family member and you may be refused services.

RIGHT TO CONSENT OR REFUSE You can be treated without consent only if there is an emergency and in the opinion of your therapist failure to act immediately would jeopardize your health. Otherwise, you may refuse treatment and change your mind at any time. Discuss your objections with your therapist. Try to be sure of what you do or do not want.

RIGHT TO ACCESS YOUR RECORDS You have a right to request in writing access to and may obtain a copy of the medical and billing records that MMHC clinical staff maintain. Your clinician can deny your request only if he/she has a substantial belief the information would be harmful to you. You are entitled to see such information about yourself. This includes the therapist's treatment plan and notes. Your therapist or the Clinic Director or his designee are the only persons allowed to review your treatment related records with you. Do not expect the office staff to review your file or photo copy information for you. A charge does apply for a copy of your records per Minnesota State Statute

RIGHT TO REQUEST TO CHANGE INACCURATE INFORMATION You have the right to request a MMHC Staff to amend your health information. MMHC requires clients to make requests for amendments in writing and to provide a reason to support a requested amendment, provided that he/she informs clients in advance of such requirements. MMHC makes the final determination with those requests.

RIGHT TO REQUEST RESTRICTIONS ON DISCLOSURE The Privacy Rule permits clients *to request* restrictions on the use and disclosure of parts of the client's PHI or the entirety for treatment, payment, and health care operations, or to family members. While MMHC clinical staff is not required to agree to such restrictions, MMHC clinical staff will attempt to accommodate a reasonable request. Once MMHC clinical staff have agreed to a restriction, MMHC clinical staff may not violate the restriction; however, restricted PHI may be provided to another health care provider in an emergency treatment situation.

The Privacy Rule also permits clients to request receiving communications from MMHC through alternative means or at alternative locations. As required by the Privacy Rule, MMHC clinical staff will accommodate all reasonable requests.

MINORS' RIGHT TO INFORMATION All minor clients under the age of 18 years old must have the consent of their parents following an initial intake session to receive further treatment services.

RIGHT TO A SAFE ENVIRONMENT No weapons are allowed on the premises. For safety purposes no child should be left unattended on the premises.

REQUIRED OR PERMITTED BY LAW We may use or disclose your medical information when we are required or permitted to do so by law. For example, we must disclose your medical information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your medical information when authorized by worker's

compensation or similar laws. We may disclose your medical information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

LAW ENFORCEMENT We may disclose your medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process. Under limited circumstances, such a court order, warrant, or grand jury subpoena, we may disclose your medical information to the law enforcement officials. We may disclose limited information to a law enforcement official concerning medical information if a suspect, fugitive , material witness, crime victim, or missing person. We may disclose the medical information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances.

ABUSE OR NEGLECT We may disclose your medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your medical information to the extent necessary to avert a serious threat to your health or safety or the health or the safety of others. We may disclose medical information when necessary to assist law enforcement officials to capture an individual who has admitted to participate in a crime or has escaped from lawful custody.

NATIONAL SECURITY We may disclosed to military authorities the medical information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official, medical information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or individual under certain circumstances.

YOUR RESPONSIBILITIES

TO BE HONEST You are responsible for being honest and direct about everything that relates to you as a client. Tell the staff exactly how you feel about the things that are happening to you.

TO UNDERSTAND AND FOLLOW THE TREATMENT PLAN You are responsible to actively participate in the development of your treatment plan. Your ideas on what you need to do are as important as the therapist's. You are also responsible for understanding the treatment plan. If you do not understand, ask your therapist. Be sure you do understand and make efforts to follow your treatment plan since this is important to the success of your treatment plan. If you don't want to or think you can accomplish your goals, let your therapist know.

TO KEEP APPOINTMENTS... You are responsible for keeping your scheduled appointments; refer too: Fee Policies & Authorization of Benefits Agreement.

TO KNOW YOUR THERAPIST Therapists must have special formal training in order to be licensed or certified in their specific fields. You are entitled to ask your therapist what his/her training is, where it was received and if he/she is licensed/certified.

TO BE RESPONSIBLE FOR YOUR VALUABLES You are responsible for your valuables both on your person as well as in your car and your car itself. Minnesota Mental Health Clinics cannot be held responsible for loss or damage to your property on the premises.

CRISIS INFORMATION Should you have an emergency, go to your hospital emergency room or call 911. Should you need to talk to someone right away, the following crisis lines are available 24 hours, seven days a week.

Crisis Connection	612-379-6363
Dakota Co. Crisis Response Unit	952-891-7171
Washington Co. Crisis Line	651-777-5222
Ramsey Co. Crisis Service	651-266-7900
Hennepin Co. Suicide Prevention	612-873-2222
Hennepin Co. Crisis Intervention Center	612-873-3161
Anoka Co. Crisis Intervention	763-755-3801
Carver/Scott Co. Crisis Service	952-442-7601
First Call for Help (Not an emergency service but information and referral.)	211

Should you ever be in a crisis situation, you can ask your therapist to help you develop a crisis plan to prepare you to deal with an emergency that might arise. This plan lists things you can do to seek help during a crisis. Should you have an urgent need, you can call and leave a message for your therapist during clinic hours. If your matter cannot wait, you may communicate your urgent need to our office staff and they will contact your therapist immediately. If you should call after clinic hours, our after hours answering service will assist you as necessary and contact the on-call after hours therapist.

ADDRESS CHANGE
So that we may contact you whenever necessary, we will rely upon you to notify us of any changes in your address, home telephone number or work telephone number.

_____ _____
Print Client Name Client Signature Date

_____ _____
Print Parent/Guardian Name Parent/Guardian Signature Date

Minnesota
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PNC#_____

Referral for Psychiatry Services

In the course of your therapy treatment at any of the Minnesota Mental Health Clinics, you may be referred by your therapist for a psychiatry evaluation and medication management. During your therapy treatment you may continue to see a staff psychiatrist. Once your therapy treatment is completed, our staff will assist you in transferring your medication needs to your family doctor or other community resources. Limited psychiatry resources are available to meet the needs of our clients. Psychiatry services are reserved for clients actively involved in therapy treatment.

You will need to make your own arrangements for a transfer of care; including contacting and scheduling appointments. Many providers are scheduled far in advance and it may take some time to arrange an appointment. The clinic will transfer your records with the proper releases. Please check with your insurance provider to assure your fees will be covered.

** If you fail or late cancel with less than 48 hours your initial psychiatry appointment for any reason, we will not reschedule any further psychiatry services**

_____
Client Name (please print)

_____ _____
Signature Date

_____ _____
Parent or Guardian Signature Date